Attending Physician's Statement & itemized receipt

Month Y M Hospitalization / Out patient or Home

Name of Patient (Last , First)

Male / Female Date of Birth Y M D Age

Date of First Diagnosis Y M D Duration of Treatment D

Date 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

Was the treatment required as a result of an accidental injury?	Yes	Name
	No	Address

(1)	Fee for initial office visit	$	
(2)	Fee for follow-up office visit	$	
(3)	Fee for home visit	$	
(4)	Fee for hospital visit	$	
(5)	Hospitalization	$	
(6)	Consultation	$	
(7)	Operation	$	
(8)	X-ray examination	$	
(9)	Medication	$	
(10)	Anesthetics	$	
(11)	Operating room charge	$	
(12)	Inspection	$	
(13)	Other(specify)		
	( )	$	
	( )	$	
	( )	$	
	( )	$	
	Total	$	

Name of Illness or Injury preferably with Number of International Classification of diseases for the use National Health Onsurance (See the other side of this form)

No. ( )

No. ( )

No. ( )

No. ( )

Nature and Condition of Illness or Injury (in brief)

Name and Address of Attending Physician

Name :

Address : Home phone

Office phone

Date Y M D Signature

Prescription , Operation and Any other Trearments (in brief)	